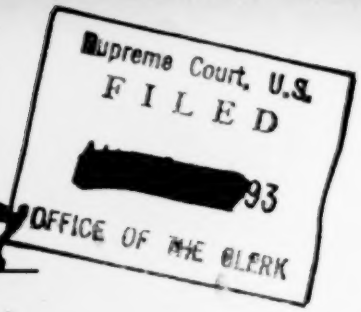


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No. 93-287

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SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1993

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JUL 23 1993

GEORGE G. WISE, RONALD GUBIS, DON WAKELAND, ALFRED FIKES, WILBERT H. HOLUB, J. G. FLEMING, DONALD A. RICHARDSON, ROY L. JORDAN, JAY F. NABOURS, FRANK STURDEVANT, MARVIN HEWETT, RICHARD W. PITTS, BUDDY G. NOTGRASS, VERNON O. WOOD, HARLIS W. LOGAN, RICHARD A. DAIGLE, J. KENNETH LUTHER, JERRY L. McNEESE, ROGER F. BOYD, W. R. CAVINESS, BOBBY L. HUGHES, ALBERT HYMAN, EVAN O. BIGELOW, and MARLON D. McCUTCHEN

Petitioners

v.

EL PASO NATURAL GAS COMPANY

Respondent.

Petition for Writ of Certiorari
To the United States Court of Appeals
For the Fifth Circuit

APPENDIX TO
PETITION FOR WRIT OF CERTIORARI

Thomas A. Spieczny
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EDITOR'S NOTE

THE FOLLOWING PAGES WERE POOR HARD COPY AT THE TIME OF FILMING. IF AND WHEN A BETTER COPY CAN BE OBTAINED, A NEW FICHE WILL BE ISSUED.

INDEX TO APPENDIX

1) Decision of the U.S. Court of Appeals for the Fifth Circuit dated March 25, 1993 — Page 1-50

2) U.S. District Court Order Regarding Motions for summary Judgment dated March 10, 1992. — Page 51-58

3) Order denying Petition for Rehearing dated April 26, 1993. — Page 59

4) EPNG 1977 SPD — Page 60-85

5) EPNG 1980 SPD — Page 86-111

George G. WISE, et al,

Plaintiffs-Appellants,

v.

EL PASO NATURAL GAS COMPANY,

Defendant-Appellee.

No. 92-8125

United States Court of Appeals,
Fifth Circuit.

March 25, 1993.

Before WILLIAMS, HIGGINBOTHAM and BARKSDALE, Circuit Judges.

JERRE S. WILLIAMS, Circuit Judge:

Plaintiffs appeal from the district court's grant of summary judgment in favor of their former employer, El Paso Natural Gas Company (which, along with its successors in interest, we refer to as "El Paso"). In October 1985, El Paso informed its workers that anyone who retired after a specified cut-off date would no longer

have their health insurance paid by the company. Plaintiffs, upset that they "must devote a substantial portion of what was anticipated to be disposable retirement income to pay escalating health insurance premiums," argue that El Paso is contractually bound to provide their health insurance. They also maintain that under the Employment Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 ("ERISA"), the company is statutorily obliged to do so. The district court disagreed as to both assertions. It concluded that El Paso had no statutory or contractual obligation to continue post-retirement benefits and was free to eliminate paid coverage. We affirm.

I. FACTS AND PRIOR PROCEEDINGS

The underlying facts of this important case are uncontested, Plaintiffs are

long-time employees of El Paso. In 1959, fifteen years before the enactment of ERISA, El Paso began providing comprehensive medical insurance to its retirees. From that date, the post-retirement medical plan (the "Plan") has been governed by a series of underlying insurance policies or plan documents which expressly grant El Paso the unilateral authority to modify or terminate coverage at any time. El Paso has modified the Plan many times, choosing both to decrease and increase benefits. From 1959 through 1976, the benefits plan was described in informal documents such as brochures and handbooks.

Upon ERISA's effective date in 1977, El Paso began to spell out the Plan's various rights and benefits in formal Summary Plan

Descriptions ("SPDs").[1] Twice in 1977 and again in 1980, El Paso prepared and distributed to eligible participants editions of the statutorily-mandated SPD. All three versions of the SPD are identical for purposes of the instant case and contained the following passage, from which Plaintiffs glean a promise of infinite duration: "Upon retirement, you, your spouse, and eligible children under 19 years of age are automatically insured for retirement health care benefits and the Company pays the entire cost." None of these SPDs expressly addressed El Paso's reservation of the right to amend or terminate the Plan's benefit provisions, but they advised readers to consult the Plan's official text for complete information.[2]

In December 1983, Burlington Northern, Inc. acquired El Paso, and, following a transition period, began to provide through its own plans the benefits flowing to El Paso's active workers and retirees. Unlike the parent company and Burlington's other subsidiaries, however, El Paso continued to pay the full cost of its retirees' insurance. A new disclosure rule floated by the Financial Accounting Standards Board, however, dramatically altered the situation. The proposed requirement, that employers must reflect on their balance sheets the present value of the estimated future costs for retirees' medical benefits, portended a serious impact on Burlington's financial statements and prompted Burlington to commission an actuarial analysis of how the rule might shape its recorded

liabilities. See Financial Accounting Standards No. 106: Employers' Accounting for Postretirement Benefits Other Than Pensions (1990).[3]

According to El Paso's motion for summary judgment, the new balance sheet liability and annual expenses were conservatively estimated to be "significantly greater than ... for all of the other Burlington-held companies added together." Under the heading LEGAL CONSIDERATIONS, the actuarial report noted a recent pro-retiree court ruling and evinced concern that El Paso's pre-1985 SPDs, unlike Burlington's, may have failed to include language authorizing unilateral amendment and/or termination.[4] Thus, in March and June 1985, El Paso began to lay the groundwork for future changes by

issuing new SPDs which, for the first time, included the following language under the heading **"OTHER IMPORTANT INFORMATION"**:

> The Company reserves the right to alter, amend, delete, cancel or otherwise change the plan or any of the provisions of the plan at any time [sic]. If the plan is terminated, coverage for you and your eligible family members will end.

A few months later, in October 1985, El Paso exercised that reserved right when it announced that it would continue to extend benefits only for employees who retired on or before March 1, 1986; anyone retiring after that designated cut-off date would forfeit company-paid coverage.[5]

On behalf of himself and other Plan participants, all of whom retired between October 1986 and August 1989, George G. Wise initiated this action in state court to contest El Paso's refusal to pay for their post-retirement health coverage under the Plan. Wise alleged a variety of state common law claims, including breach of contract, negligence, and breach of the duty of good faith and fair dealing. El Paso removed the action to federal court on the basis of ERISA preemption. See 29 U.S.C. §1144(a). The parties now seem to agree that the instant suit is one to enforce the terms of an employee benefit plan under 29 U.S.C. §1132(a)(1)(B).[6] On March 10, 1992, the district court granted El Paso's motion for summary judgment. Plaintiffs timely appealed.

II. DISCUSSION

A. Standard of Review

[1] Although it is a "comprehensive and reticulated statute," Nachman Corp. v. Pension Benefit Guaranty Corp., 446 U.S. 359, 361, 100 S.Ct. 1723, 1726, 64 L.Ed.2d 354 (1980), ERISA fails to set out the applicable standard of review for actions under §1132(a)(1)(B) challenging benefit eligibility determinations. The Supreme Court has filled the gap. We review de novo §1132(a)(1)(B) actions challenging denials of benefits where the benefit plan fails to give the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the plan's terms. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 956, 103

L.Ed.2d 80 (1989). In this case, neither party has pointed to any Plan provision that expressly grants El Paso, the Plan's administrator, discretionary authority regarding entitlements. Accordingly, the district court's decision will be tested under the broader de novo standard. See Schultz v. Metropolitan Life Ins. Co., 872 F.2d 676, 678 (5th Cir. 1989).

B. El Paso's Right to Amend and Terminate Coverage

We are spared a significant inquiry. As mentioned above, neither party disputes that the arrangement in question falls with ERISA's statutory definition of an "employee welfare benefit plan":

> [A]ny plan, fund, or program ... maintained by an employer ... to the extent that such plan, fund, or

> program was established or is maintained for the purpose of providing for its participants or their beneficiaries ... (A) medical, surgical, or hospital care or benefits[.]"

29 U.S.C. §1002(1).

Indeed, the Plan fits easily within the Act's broad coverage. See generally Id. at §1002; see, e.g., Meredith v. Time Ins. Co., 980 F.2d 352, 354-57 (5th Cir. 1993) (explicating ERISA's various definitional provisions).

1. ERISA's statutory requirements

It is undisputed that nothing in ERISA requires an SPD to reference amendment rights or procedures. While Plaintiffs concede that an SPD need not specify that it is subject to amendment,[7] they cite 29

U.S.C. § 1022(b), which requires an SPD to state the "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits." The gravamen of Plaintiffs' complaint is this: because § 1022(b) requires an employer to warn participants of possible decreases in their benefits, El Paso "was not free to amend the plan if the amendment caused a loss of benefits." (emphasis in original). Under the SPD heading, "**TERMINATION OF BENEFITS AND CONVERSION PRIVILEGES**," El Paso listed three triggering events that would terminate a retiree's insurance: (1) death of the retiree; (2) remarriage of a surviving spouse; and (3) a dependent child reaching the age of 19. Plaintiffs leap upon this seeming exclusivity:

> This language does not state, or even indirectly imply, that the coverage will be terminated for any other reason.... [The pre-1985 SPDs] indicate three, and only three, instances in which such coverage will end.... Neither document in any way directly or indirectly reserves any right to alter, amend, modify or change the policy. (emphasis in original).

In sum, since the earlier SPDs failed to meet §1022(b)'s disclosure requirement by including the possibility of unilateral amendment or termination, Plaintiffs insist that El Paso is estopped under ERISA from abolishing free, lifetime coverage.

[2] The district court disagreed, pointing to the Plan itself and to the SPDs issued in 1985, all of which reserved to El Paso the unqualified right to alter or eliminate coverage. From this, the court concluded that "[r]etired employees such as the Plaintiffs in this case cannot claim entitlement to employer paid health benefits in perpetuity where the plan itself and the SPD make it clear that those benefits can be amended, modified, or even terminated at any time." Upon a review of applicable caselaw, we agree with the district court.

(a) no vesting

[3,4] Congress has conspicuously chosen to exempt welfare benefit plans from the full breadth of ERISA's extensive requirements. Compare 29

U.S.C. §1002(2)(A) with §1002(1) (distinguishing "employee pension benefit plans" from "employee welfare benefit plans"). Welfare benefits such as medical insurance, which may be ancillary to but are not part of a pension plan, are not subject to the rather strict vesting, accrual, participation, and minimum funding requirements that ERISA imposes on pension plans. See 29 U.S.C. §§ 1051 et seq. and §§ 1081 et seq. Accordingly, this Court and every other Circuit Court that has considered the question agree that "ERISA simply does not prohibit a company from eliminating previously offered benefits that are neither vested nor accrued." Phillips v. Amoco Oil Co., 799 F.2d 1464, 1471 (11th Cir. 1986), cert. denied, 481 U.S. 1016,

107 S.Ct. 1893, 95 L.Ed.2d 500 (1987); see e.g. McGann v. H & H Music Co., 946 F.2d 401, 405-07 (5th Cir. 1991), cert. denied sub nom. Greenberg v. H & H Music Co., ___ U.S. ___, 111 S.Ct. 517, 112 L.Ed.2d 529 (1990).

The disparate treatment accorded welfare plans is not accidental; indeed, its underlying rationale is highly pertinent to our decision today. In a similar case involving retirees who challenged their employer's decision to modify unilaterally its benefits plan, the Second Circuit explained:

> With regard to an employer's right to change medical plans, Congress evidenced its recognition of the need for flexibility in rejecting the automatic vesting of welfare plans. Automatic vesting was rejected because

> the costs of such plans are subject to fluctuating and unpredictable variables. Actuarial decisions concerning fixed annuities are based on fairly stable data, and vesting is appropriate. In contrast, medical insurance must take account of inflation, changes in medical practice and technology and increases in the costs of treatment depending on inflation. These unstable variables prevent accurate predictions of future needs and costs.

Moore v. Metropolitan Life Ins. Co., 856 F.2d 488, 492 (2d Cir. 1988).

We do not have the power to assume the legislator's role and welcome additional layers of obligations. The provision must be read in the light of ERISA's

sweeping complexity. This is clearly not a case of inadvertent omission. In such cases of deliberate legislative inaction, the Supreme Court has issued a valuable admonition: "[L]egislative silence is not always the result of a lack of prescience; it may instead betoken permission or, perhaps, considered abstention from regulation. In that event, judges are not accredited to supersede Congress or the appropriate agency by embellishing upon the regulatory scheme. Accordingly, caution must temper judicial creativity in the face of legislative or regulatory silence." Ford Motor Credit Co. v. Milhollin, 444 U.S. 555, 565, 100 S.Ct. 790, 797, 63 L.Ed.2d 22 (1980).

[5] Since an employee's interest in such benefits is not statutorily vested,

El Paso is under no continuing obligation to provide them under ERISA. It possesses the right to amend or terminate coverage at any time. Section 1022(b) relates to an individual employee's eligibility under then existing, current terms of the Plan and not to the possibility that those terms might later be changed, as ERISA undeniably permits.

(b) can change with notice

[6] Against this established law, two recent opinions from this Court interpreting ERISA's notification provisions posed similar disclosure issues and support our decision today. In Whittemore v. Schlumberger Technology Corp., 976 F.2d 922 (5th Cir. 1992), plaintiffs were former Schlumberger employees who sought severance pay under

a provision of the company's policy manual that provided for such pay in lieu of notice of termination. A December 1988 amendment, however, had revoked that practice if employees were terminated within a prescribed time and offered full-time employment by a company acquiring the Schlumberger division in which the employees worked. In Whittemore, the amended severance plan, a welfare benefit plan under ERISA, became effective before plaintiffs' division was sold to another company. Although admitting that the amendment "technically occurr[ed] before the employees' termination," Plaintiffs argued vigorously that Schlumberger violated ERISA by failing fully to disclose the terms of the amendment prior to the employees' discharge. In an analysis

applicable to the instant case, we observed:

> Even if this concession [that the amendment occurred prior to termination] were not enough, the district court specifically found that Schlumberger complied with ERISA's disclosure requirements in that "plaintiffs admit receiving copies of the amended severance ... plan on February 7, and admit receiving a summary description of this plan change on March 8, 1989." The plaintiffs do not dispute these facts.
>
> The plaintiffs acknowledge that Schlumberger gave notice within the time permitted by ERISA. They argue only that "such a technical reading of the disclosure provisions ... work

> [sic] an inequitable result and give [sic] effect to form over substance." We conclude, to the contrary, that Schlumberger was entitled to give notice within the statutory notice period and was not required to provide it sooner. The plaintiffs' argument is without merit.

Id. at 923-24 (emphasis added).

The instant plaintiffs concede that they received the revised SPDs prior to El Paso's termination. Moreover, El Paso provided a reasonable window during which eligible employees could choose to retire with full, company-paid coverage. El Paso's workers, like those in Whittemore, were placed on notice, however perfunctory, that retirement after the prescribed date would result in the forfeiture of free coverage.

Our recent decision in Godwin v. Sun Life Assurance Co. of Canada, 980 F.2d 323 (5th Cir. 1992), decided after arguments in the instant case, also concerned ERISA's disclosure requirements. In Godwin, the plaintiff contended that an amendment to his welfare benefit plan was inapplicable to him because he had never received personal notice of the amendment. Although Sun Life issued updated SPDs following each amendment to the plan, Godwin maintained that his nonreceipt of notice of the change rendered it invalid as to him. Framing the issue as whether the plan sponsor complied with the ERISA requisites for plan modifications with respect to Godwin, we held:

We agree with the district court that an amendment to a welfare benefit plan is valid despite a beneficiary's lack of personal notice, unless the beneficiary can show active concealment of the amendment, Blau v. Del Monte Corp., 748 F.2d 1348, 1352 (9th Cir.), cert. denied, 474 U.S. 865, 106 S.Ct. 183, 88 L.Ed.2d 152 (1985), [footnote omitted], or "some significant reliance upon, or possible prejudice flowing from" the lack of notice. Govoni v. Bricklayers, Masons and Plasterers Int'l Local No. 5 Pension Fund, 732 F.2d 250, 252 (1st Cir. 1984). Here, there is no evidence of active concealment, and Godwin can show neither significant reliance nor prejudice from his

alleged lack of notice. (footnote omitted).

Id. at 328.

In the instant case, Plaintiffs' assertions are weaker than Godwin's. They cannot dispute that they received personal and unambiguous notice of the prospective change months before it became effective. El Paso concedes that the SPDs could possibly suggest an "arguable commitment" to continue coverage for workers retiring before the effective date and points out that it has in fact extended post-retirement insurance to such retirees. The instant plaintiffs, however, are asking us to do what neither Congress nor any other court has ever done - impose vesting for employees who had not retired as of the date of the disputed change.

Plaintiffs complain strenuously that no pre-1985 SPDs contained the amendment/termination language. This omission, they insist, is tantamount to a promise to maintain post-retirement health care: "If the SPDs ... contain such a promise, EPNG must honor its commitment and cannot avoid that obligation, even by amending its plan documents." We do not agree, particularly when (1) ERISA does not mandate the inclusion within SPDs of amendment rights or procedures and (2) any pre-1985 silence is followed by an unequivocal statement to the contrary. El Paso's failure to include that which ERISA does not require cannot act to prejudice El Paso by imposing an infinite duty. Although Plaintiffs acknowledge

that it is "technically true" that amendment procedures and rights need not be included in the SPD, they insist that when amendments compromise benefits previously offered, they must be precluded under §1022(b). This argument is fanciful. Plaintiffs must concede that amendments, almost by definition, do not always herald pro-beneficiary news. The average plan participant must realize that amendments to welfare benefit plans are not enacted for the sole purpose of augmenting benefits, but often to diminish them as well.

We are sensitive to Plaintiffs' earnest concerns and realize that today's decision works a significant hardship on workers who have invested, in many cases, most of their lives in service to the company. Across the nation, companies

faced with rapidly rising costs and worried about their competitiveness are paring retiree benefits that were once considered sacrosanct. But ERISA simply does not grant employees unfettered rights to the corporate treasury. Employers need not abandon prudent business behavior when marketplace forces compel them to rethink earlier offers of contingent, non-vested benefits. In light of today's spiraling health care costs, cutbacks in government-sponsored health care coverage (Medicare), and our ever-aging population, Congress may enact changes. But the current ERISA requires no more.

2. Contractual Vesting?

There remains the question whether the instant dispute can be recognized as a

contract case, rather than a statutory one. Plaintiffs urge this interpretation, insisting that even if ERISA does not provide a statutory bar to El Paso's actions, the company has incurred contractual obligations beyond ERISA to provide free, lifetime coverage.

[7] We held above that although ERISA includes elaborate vesting requirements for pension plans, see 29 U.S.C. § 1053, "it does not require that welfare plan benefits 'vest' or that an employer maintain them at a certain level." Vasseur v. Halliburton Co., 950 F.2d 1002, 1006 (5th Cir. 1992); see also McGann, 946 F.2d at 405. Although ERISA generally allows employers to modify or discontinue such plans at will so long as the procedure followed is consistent with the plan and the Act, we have held that

an employer's welfare plan itself may designate a vested benefit. In Vasseur we stated: "An employer can oblige itself conctractually to maintain benefits at a certain level in ways that are not mandated by ERISA." 950 F.2d at 1006. See also, e.g., In re White Farm Equipment Co., 788 F.2d 1186, 1193 (6th Cir. 1986).

[8, 9] It follows that El Paso could have waived its statutory right to modify or terminate benefits and vested its workers contractually with the right to receive free lifetime coverage. We cannot find such an obligation, however, anywhere in the record in this case. Such extra-ERISA commitments must be found in the plan documents and must be stated in clear and express language.

Neither the particular terms of El Paso's master policy nor its pre-1985 SPDs come close to encompassing such a binding pledge. See, e.g., Alday v. Container Corp. of America, 906 F.2d 660, 665 (11th Cir. 1990) ("[A]ny retiree's right to lifetime medical benefits at a particular cost can only be found if it is established by contract under the terms of the ERISA-governed benefit plan document.") (emphasis added), cert. denied, ___ U.S. ___, 111 S.Ct. 675, 112 L.Ed.2d 668 (1991); In re White Farm Equipment Co., 788 F.2d at 1193 ("[T]he parties may themselves set out by agreement or by private design, as set out in plan documents, whether retiree welfare benefits vest, or whether they may be terminated.") (emphasis added).

El Paso's plan documents and SPDs describe the extent of benefits provided under the Plan; they make no reference to a vesting of such benefits. El Paso's statement in the pre-1985 SPDs that "[u]pon retirement, you ... are automatically insured for retirement health care benefits and the Company pays the entire cost" discussed what the Plan then provided, not whether it would be offered in perpetuity. As to yet-unretired workers, no commitments were made. Nowhere does the SPD contain specific language establishing a vesting of health benefits. If precise language denying the right to withdraw benefits had been included, such language would be contractually controlling. See Bryant v. International Fruit Products Co., Inc., 793 F.2d 118, 123 (6th Cir.) ("An

agreement that provides that an act can occur in no event and under no circumstances cannot be converted into one that permits the act by a series of amendments that first deletes the reference to the prohibition and then adds a provision permitting the forbidden act."), cert. denied, 479 U.S. 986, 107 S.Ct. 576, 93 L.Ed.2d 579 (1986).

[10] Aside from the fact that the underlying documents and the later SPDs did place employees on firm notice of the coming change, we find no reason or authority to conclude that pre-1985 silence in the SPDs is somehow tantamount to an affirmative contractual commitment and that El Paso's earlier SPDs impliedly cede the right to later amend or discontinue coverage. While clear and

unambiguous statements in the summary plan description are binding, the same is not true of silence. There is nothing in the way of context, inference, or presumption to persuade us otherwise. Contractual vesting is a narrow doctrine. To prevail, Plaintiffs must assert strong prohibitory or granting language; mere silence is not of itself abrogation.

[11] Even assuming, however, that the pre-1985 SPDs contained an implied promise of continued benefits for future retirees, these earlier summaries cannot govern the instant case because they are no longer in effect. The SPDs issued in 1985 cover these plaintiffs before us and therefore control our analysis. El Paso's earlier SPDs cannot be read in isolation, and in no way can they be construed to preclude the possibility of

future amendment. Upon a careful review of the summary judgment record, and with particular emphasis upon the applicable 1985 SPDs which clearly highlight El Paso's right to amend or terminate post-retirement benefits, we conclude that no basis can be found in the language of the earlier SPDs or in the plan documents to counter El Paso's reserved right to do so. "Absent such a contractual assurance, ERISA permits an employer to decrease or increase benefits." Vasseur, 950 F.2d at 1006.

Finally, we address Plaintiffs' argument that the 1985 SPDs are themselves inconsistent and that the rules of construction announced in our recent case, Hansen v. Continental Insurance Company, 940 F.2d 971 (5th Cir. 1991),

mandate that we adopt the most pro-beneficiary interpretation. Specifically, Plaintiffs contend that El Paso's failure to include the possibility of amendment or termination under the SPD heading, "**WHEN YOUR COVERAGE WILL END**," (listing it instead under the heading "**OTHER IMPORTANT INFORMATION**"), must be construed as a promise to provide free health benefits. "Under Hansen," the plaintiffs maintain, "the test is whether or not one provision of an SPD, taken in its most natural reading, would entitle Plaintiffs to lifetime benefits. If so, they are entitled to lifetime benefits." (citing Hansen, 940 F.2d at 981, n. 7). We agree that Hansen is a case of significant guidance and authority on this issue, and Plaintiffs cite the general rule accurately. But close

analysis reveals that it does not buttress their position.

In Hansen, the plaintiff disputed payments made to him under a group accidental health and dismemberment policy following the death of his wife in an automobile accident. Hansen contended that under the insurer's SPD, he was due $120,000, 60 percent of the amount of coverage. Continental relied instead upon the conflicting terms of the underlying policy and responded by tendering a check for $80,000, 40 percent of the principal sum. The company argued that the SPD had to be read in concert with the plan document, and if doing so revealed ambiguity or conflict, the plan's terms must control. We disagreed. After finding federal

jurisdiction under ERISA, we determined that the essential purpose of an SPD - "to enable the average participant in the plan to understand readily the general features of the policy" - would be undermined if workers were held to the complex, master policy whenever the statutorily-mandated SPD was either ambiguous or in outright conflict with the policy. Id. at 981. Refusing to adopt a rule that would "eviscerate" ERISA's requirement that an SPD be "sufficiently accurate and comprehensive to reasonably apprise" plan participants of their rights and duties under the plan, we concluded:

> [T]he ambiguity in the summary plan description must be resolved in favor of the employee and made binding

against the drafter. Any burden of uncertainty created by careless or inaccurate drafting of the summary must be placed on those who do the drafting, and who are most able to bear that burden, and not on the individual employee, who is powerless to affect the drafting of the summary or the policy and ill equipped to bear the financial hardship that might result from a misleading or confusing document. Accuracy is not a lot to ask. And it is especially not a lot to ask in return for the protection afforded by ERISA's preemption of state law causes of action - causes of action which threaten considerably greater liability than that allowed by ERISA.

Id. at 981-82 (and quoting 29 U.S.C. § 1022(a)(1).

Plaintiffs urge that the present case parallels our concerns in Hansen, where we addressed Continental's argument that the certificate of insurance that was included at the back of the SPD - and which asserted a pay-out percentage of 40 percent - should be considered part and parcel of the SPD. Assuming that erroneous contention to be true, we still saw no help to Continental since "[a]t least one provision of the summary plan description, taken in its most natural reading, would entitle Hansen to 60% of the principal sum." Id. at 981 n. 7. Plaintiffs focus upon this narrowly-used language:

> Certainly, parts of the 1985 SPD, taken in their most natural natural

> reading ... constitute a commitment for non-contributory retiree insurance until death, remarriage of a surviving spouse, or loss of eligibility status by dependent children. Hence, under the rationale of footnote 7, Plaintiffs are entitled to that benefit. The concurring opinion of Judge Garwood is expressly based upon footnote 7.

The above language, however, was used in a carefully limited context. A careful reading of Hansen, and particularly footnote 7, reveals that its principal concern was with positive inconsistencies, either within the SPD or between the SPD and the master documents. None exist here. The amendment/ termination language was clearly included

in the body of the SPD itself in the case before us. Plaintiffs attempt to manufacture ambiguity by asserting that El Paso's inclusion of amendment/ termination authority within the 1985 SPDs was misplaced - listed under **"OTHER IMPORTANT INFORMATION"** instead of under **"WHEN YOUR COVERAGE WILL END"** - and that this location created irreconcilable ambiguity. This argument is without merit. As we held in Hansen, "the summary plan description must be read as a whole. It would be error to attend only to one paragraph, page, or portion of the summary." Id. at 981 (citing Sharron v. Amalgamated Ins. Agency Servs. Inc., 704 F.2d 562, 566-67 (11th Cir. 1983)). Based upon our reading of the SPDs as an integrated whole so as to give effect to all of the provisions,

Plaintiffs' argument that El Paso has promised lifetime continuation of employer-paid medical benefits must fail.

[12, 13] Although a beneficiary's view of an SPD is important, the correct interpretation cannot be "unrealistically narrow." Sharron, 704 F.2d at 566 (To "focus on only one page of the summary [would] represent[] an unrealistically narrow view of how a reasonably prudent employee would read and review this important document."). The three listed occurrences that would result in termination of an individual's benefits speak only to the elimination of coverage on an individual basis and do not address the continuation of the Plan as a whole. We find no basis in the language of the documents to contradict El Paso's

unequivocal reservation of the right to modify or eliminate coverage prospectively as to employees retiring after March 1, 1986. The terms of the governing 1985 SPDs are clear and consistent with the reservation of rights set out in the Plan itself.[8]

III. CONCLUSION

In sum, El Paso exercised its reserved, unambiguous right under ERISA to amend its Plan with respect to health benefits, and it accurately described that change in the governing 1985 SPDs. Additionally, El Paso did not incur, nor intend to incur, any extra-ERISA obligations. El Paso was free to make such a business decision pursuant to its reserved right. There being no violation of ERISA, nor any affirmative contractual

commitment denying El Paso's right to withdraw health benefit coverage, the judgment of the district court was correct.

AFFIRMED.

FOOTNOTES

1. ERISA mandates that every plan participant be given an SPD, which "shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a)(1).

2. El Paso contends that the plaintiffs did not rely upon the 1977 and 1980 SPDs in the district court but rely on them for the first time on appeal. We conclude, however,

that sufficient reference was made to these documents in the district court that the plaintiffs are not precluded from asserting their relevance on appeal.

3. The new and much-publicized accounting rule, which ultimately took effect December 15, 1992, requires employers to adopt accrual accounting to expense accumulated benefits during employees' working careers rather than the past practice of waiting until the benefits are actually paid. While the change does not represent reductions in cash flow, it dramatically erodes estimates of net worth and pre-tax earnings as employers recognize the present value of projected post-retirement benefits.

El Paso is not alone in its strong response; FASB 106 has combined with other

factors to redden the financial statements of many companies, particularly those providing generous benefits. See, e.g., Robert L. Rose, Chilly Sunset: Firms' Attempts to Cut Health Benefits Break Calm of Retirement, THE WALL STREET JOURNAL, Febr. 24, 1993, at A1 (chronicling the jarring impact on various companies and their employees, and the firms' sober responses); Vineeta Anand, INVESTOR'S BUSINESS DAILY, Oct. 2, 1992, at Executive Update; Benefits, 4 (same); Lee Berton and Robert J. Brennan, Some Companies Use Subtle Methods to Curb the Cost of Retiree Benefits, THE WALL STREET JOURNAL, Febr. 24, 1993, at A14 (detailing the novel, blow-softening responses of several companies).

4. Apparently, the report was referring to the class action case, Eardman v. Bethlehem Steel Corp. Employee Welfare Benefit Plans,

the approved settlement of which is cited at 607 F.Supp. 196, 215-17 (W.D.N.Y. 1985). In Eardman, retired workers contested reductions in their benefits on the ground that the plan documents had not reserved the right to amend. The district court had earlier found for the workers. Id. at 196-215 (W.D.N.Y. 1984). The opinion approving the settlement recognized the risk of reversal as one basis for approval.

In light of a recent article examining the implications of FASB 106, the report's concerns proved to be prescient: "Experts say that employers should also examine the legal implications. For example, employers may be unable to alter plans unilaterally if they have not specifically retained that right and put retirees on notice that the plan could be changed." New Accounting Rule

for Retiree Benefits Will Force Employers to Change Practices, BNA PENSIONS & BENEFITS DAILY (Nov. 4, 1992) (emphasis added).

5. Of special note is the fact that El Paso, while ceasing to provide free benefits for employees retiring after March 1, 1986, has nonetheless continued to maintain its Plan and to cover post-March 1986 retirees. The record reflects the following:

> Under the Plan, post-March 1986 retirees are provided, at their own cost, (i) a number of benefits that would not be readily available to them in insurance contracts and (ii) benefits at group rates significantly better than they could acquire as individuals in the open market. In addition, (iii) EPNG pays the full administrative costs of the Plan, including the portion of such costs related to post-March 1986 retirees.

6. 29 U.S.C. §1132(a)(1)(B) provides:

A civil action may be brought -

(1) by a participant or a beneficiary -***

(B) to recover benefits due him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

7. The plaintiffs acknowledge that the underlying plan documents, as distinguished from the 1977 and 1980 SPDs, expressly set forth the company's right to modify the plan.

8. We do not consider the issue whether plan participants should prevail in instances where the employer fails to inform them in the SPD that their benefits are subject to unilateral change and/or termination. That issue does not arise in this case.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS

GEORGE G. WISE, et al,

Plaintiffs,

v.

EL PASO NATURAL GAS COMPANY,

Defendant.

NO. EP-89-CA-435-H

ORDER REGARDING MOTIONS

FOR SUMMARY JUDGMENT

This is an action by several retired employees of the El Paso Natural Gas Company. The Plaintiffs originally filed suit in state court, alleging causes of action for breach of contract, negligence, and breach of the duty of good faith and fair dealing under Texas law. The Defendant removed the case to this Court, claiming federal preemption by the Employee Retirement Income Security Act

(ERISA), 29 U.S.C. §§1001 **et seq.** The Plaintiffs filed a motion to remand to state court, but the motion was denied. The Court found that the action should proceed in federal court as one to enforce the terms of an employee benefit plan under 29 U.S.C. §1132(a)(1)(B). Both sides have filed motions for summary judgment.

Since 1959, Defendant El Paso Natural Gas Company has maintained employee welfare benefit plans for its employees. With the passage of the Employee Retirement Income Security Act in 1974, the Defendant's plan came under the coverage of the Act, and was required to comply with its terms. 29 U.S.C. §1003(a). One of the requirements of ERISA is that every plan participant be provided with a summary plan description

written in a manner calculated to inform each plan participant of his or her rights and obligations under the plan. 29 U.S.C. §1022(a)(1). Pursuant to this requirement, the El Paso Natural Gas Company issued and periodically revised a summary plan description (SPD). Prior to October, 1985, the plan provided, and the SPD reflected, that the company would continue to pay for health insurance for its retired employees. On October 28, 1985, the Defendant's employees were informed that all employees who retired after March 1, 1986, would no longer have their health insurance paid for by the company. In this lawsuit, the Plaintiffs contend that the Defendant made a clear and unequivocal commitment to its employees through the summary plan description that it would provide health

insurance to retirees in perpetuity, and that ERISA requires it to continue doing so. The Defendant counters by saying that the plan itself contained a provision that the company could amend it at any time, and that it simply did so with respect to health insurance benefits for employees retiring after March 1, 1986.

The summary plan description which is required by law, is binding upon the employer. It is now well settled that in case of a conflict between the summary plan description and the terms of the plan itself, the summary plan description shall govern. **Hansen v. Continental Insurance Company**, 940 F.2d 971, 982 (5th Cir. 1991); **McKnight v. Southern Life and Health Insurance Company**, 758 F.2d 1566, 1570 (11th Cir. 1985); **Edwards v. State**

Farm Mutual Automobile Insurance Company, 851 F.2d 134, 136 (6th Cir. 1988). In this case, therefore, the Defendant cannot rely on the plan in case of conflict between the plan and the SPD. Under those circumstances, the language of the SPD controls.

The Defendant fares better, however, with another argument. The law is clear that the summary plan description must be read as a whole. An employee cannot pick out one paragraph, page, or portion of the summary plan description and rely on that while ignoring the balance of the document. **Hansen v. Continental Insurance Company, supra** at 981; **Sharron v. Amalgamated Insurance Agency Services, Inc.** 704 F.2d 562, 566-67 (11th Cir. 1983). As part of the summary judgment proof, the Defendant has offered examples

of SPDs issued in March, 1985 (Defendant's Exhibit 24) and June, 1985 (Defendant's Exhibit 25), each of which contains the following language:

> Continuance of the Plan
>
> The Company reserves the right to alter, amend, delete, cancel or otherwise change the plan or any of the provisions of the plan at any time. If the plan is terminated, coverage for you and your eligible family members will end. Benefits, however, for any legitimate claims incurred before the plan's termination will be paid.

This language in the SPD clearly put employees on notice that the employer reserved the right to modify or even terminate retiree health insurance benefits at any time. **Alday v. Container Corporation of America**, 904 F.2d 660, 665 (11th Cir. 1990); **McGann v. H & H Music Company**, 742 F.Supp. 392, 394

(S.D. Tex. 1990). Retired employees such as the Plaintiffs in this case cannot claim entitlement to employer paid health benefits in perpetuity where the plan itself and the SPD make it clear that those benefits can be amended, modified, or even terminated at any time. **Alday v. Container Corporation of America, supra; McGann v. H & H Music Company, supra.**

There is no genuine issue of material fact, and the Defendant is entitled to judgment in its favor as a matter of law. Therefore, the Defendant's motion for summary judgment should be granted.

It is therefore ORDERED that the Defendant's Motion for summary judgment in the above-styled and numbered cause be, and it is hereby, GRANTED.

It is further ORDERED that judgment be, and it is hereby, ENTERED in favor of the Defendant, and that the Plaintiffs take nothing by their suit.

SIGNED AND ENTERED this 10th day of March, 1992.

HARRY LEE HUDSPETH
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 92-8125

GEORGE G. WISE, et al,

Plaintiffs-Appellants,

versus

EL PASO NATURAL GAS COMPANY,

Defendant-Appellee.

Appeal from the United States District Court for the Western District of Texas

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ON PETITION FOR REHEARING
(April 26, 1993)

Before WILLIAMS, HIGGINBOTHAM and BARKSDALE, Circuit Judges.

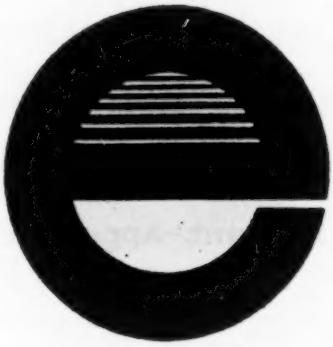
PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above entitled and numbered cause be and the same is hereby

DENIED

ENTERED FOR THE COURT:

United States Circuit Judge



RETIRED EMPLOYEES MAJOR MEDICAL/MEDICARE SUPPLEMENT

COMPREHENSIVE MEDICAL/DENTAL INSURANCE COVERAGE

Rev. 11/77

Notice to Retired Employees

Earlier this year we mailed each of you a booklet describing the Comprehensive Medical/Dental Insurance provided by the Company for Retired Employees and their Dependents.

Minor changes have been made to certain pages contained within the booklet. Rather than provide you only with the changes, we have instead reprinted the booklet, and your revised edition is enclosed. For your information the revised material is on page 2, and pages 15 through 22.

Please destroy the copy provided to you earlier this year and <u>retain this copy</u> for your permanent records.

Personnel Administration
November 1977

FOREWORD

Even though health care expenses have dramatically increased during recent years, the Company has continued to maintain a well-rounded health care program which provides the needed protection without any significant increase in cost to the insured. The Company, by paying the total premium, assumes the major impact of spiralling medical costs.

The health care benefits provided for retired employees and their eligible dependents extend a broad range of protection against most necessary medical as well as dental expenses. All benefits are a supplement to those provided through MEDICARE.

The following is intended as a Summary Plan Description of your retirement health care benefits and, in addition, serves as a vehicle of compliance as required under the Employee Retirement Income Security Act of 1974 (ERISA). Every effort has been made to describe your benefits as accurately and comprehensively as possible in order to inform you and your beneficiaries of rights and obligations under the Plan.

It should be noted that a Summary Plan Description **cannot be, nor is it intended to be, as detailed as the formal text of the insurance policy which it summarizes. Therefore, the insurance policy will be made available for review at various Company locations upon request.** (See Appendix II) Similarly, if there is any language or explanation in this booklet which you do not understand, you should contact a Personnel Representative assigned

to the office where you last worked just prior to retirement.

Finally, if there is any conflict between that which follows in this booklet and the official text of the Plan, the text of the Plan will prevail.

FACTS ABOUT THE PLAN

NAME OF PLAN

Retired Employees Major Medical/MEDICARE Supplement, Group Policy Numbers GC-40000; GM-40000

TYPE OF PLAN

Insured Welfare Plan providing comprehensive coverage for medical / dental expenses for retired employees and eligible dependents

PLAN NUMBER

501

PARTICIPATING EMPLOYER COMPANIES

The El Paso Company and Affiliated Companies (See Appendix I)

PLAN ADMINISTRATOR

The El Paso Company
304 Texas Avenue
Post Office Box 1492
El Paso, Texas 79978
Area Code 915: 543-2600

TYPE OF ADMINISTRATION

Although The El Paso Company is the named Plan Administrator for ERISA purposes, the day-to-day administration of the Plan is the responsibility of the Personnel Administration Department of El Paso Natural Gas Company at its home office, El Paso, Texas 79978.

EMPLOYER IDENTIFICATION NUMBER

74-1782256

DESIGNATED AGENT FOR SERVICE OF LEGAL PROCESS

The El Paso Company
Office of the Secretary
2727 Allen Parkway
Post Office Box 2185
Houston, Texas 77001
Area Code 713: 524-3911

Legal process may also be served upon the Plan Administrator.

SOURCE OF CONTRIBUTIONS TO THE PLAN

The full cost of providing the benefits under this Plan is paid for by the participating employer companies (excluding Special Student Coverage).

INSURER

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06156

PLAN FISCAL YEAR

December 1 - November 30

SEE APPENDIX III FOR A DESCRIPTION OF YOUR RIGHTS AND PROTECTIONS AS PROVIDED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT.

YOUR RETIREMENT HEALTH CARE BENEFITS

Eligibility

Upon retirement, you, your spouse, and eligible dependent children under 19 years of age are automatically insured for retirement health care benefits and the Company pays the entire cost. Eligibility includes:

- regular full-time employees of a participating employer who have been granted a retirement and were covered under the Employees Group Insurance Plan prior to retirement

- a spouse and/or dependent children.

In addition, a surviving spouse continues coverage subject to certain conditions. (See page 15.)

Special Student Coverage is an extension of health care benefits and is available for an unmarried dependent child who is at least age 19, but under age 23, and who is enrolled as a full-time student in an accredited institution of higher learning. Individual applications must be submitted although you must pay the monthly premium cost.

Incapacitated or handicapped dependent children may be entitled to an extension of health care benefits if disability commenced prior to the child's 19th birthday and coverage was previously in force under the group Plan. Subject to application

and subsequent approval by the insurance carrier, coverage may be extended beyond the normal age limitations. Applications for this provisional feature of the health care benefits may be obtained from the applicable Personnel office.

Identification cards have been furnished and, hopefully, the card can prove helpful in the event some type of confirmation as to coverage might be needed. If you do not have this card, you should contact the Personnel offices so that a new one can be promptly furnished.

Benefits Of The Plan

Your post-retirement medical and dental coverage includes most of the same definitions and general provisions as did your pre-retirement coverage. These include:

- covered expenses
- exclusions
- deductible carry-over and common accident provisions
- 80 and 50 percent payment after establishing the annual deductible
- coordination provisions with any other group insurance coverages.

There are, however, certain variances between the health care benefits for active employees and the retirement health care coverage, in that:

- there is a **deductible** prior to reimbursement for any covered expense, but this annual deductible is only $50 per individual

- $25,000 is the initial lifetime maximum benefit for each insured, but

- at the beginning of each calendar year, there is an automatic restoration up to $1,000 of any used benefits.

The Plan will pay 80 percent of any covered expenses (50 percent in cases of certain dental charges) in excess of the deductible in any calendar year, after taking into account any amounts subject to be paid by a primary group carrier or by MEDICARE.

The Annual Deductible

Each insured individual has a separate annual deductible of $50 and only covered expenses may be used to satisfy this deductible.

Last Quarter Carry-Over So that your reimbursable expenses cannot be subject to a deductible late in one calendar year and soon again in the next, any expenses applied against the deductible in the last three months of a calendar year may also be applied against the next year's deductible.

Common Accident If two or more insured members of your family are injured in the same accident, all Major

Medical covered expenses which result from that accident during that and the following calendar year will be combined and only one deductible will be charged, regardless of the number of family members involved.

Reimbursement Schedule

After satisfying the "Deductible" (which may be made up from any combination of covered medical or dental expenses), the following will apply:

- eighty percent (80%) of covered medical and certain dental expenses

- fifty percent (50%) of any other specified dental expense

- an annual maximum payment applicable to basically all dental expenses up to $1,000 per individual which is included in the $25,000 individual entitlement

- the annual automatic restoration provision provides for up to $1,000 of your used benefits at the beginning of each calendar year

- upon payment of an individual's maximum benefits, the respective insured's coverage ceases until eligible for the annual automatic restoration provision.

(Orthodontic care expenses will be paid at the rate of 50 percent after the

deductible is satisfied. There is a maximum lifetime orthodontic benefit of $500 which is separate and apart from the other entitlements.)

Covered Expenses

Covered medical / dental expenses subject to Plan provisions include the reasonable and actual charges which might be incurred for treatment of injury or illness, as well as the reasonable dental expenses generally recognized by professional dental standards. Covered expenses include:

- services of a licensed physician, surgeon, or dentist
- hospital room and board (up to the average semi-private room rate) and other necessary hospital expenses incurred during confinement
- services of a registered graduate nurse or licensed vocational nurse prescribed by your physician — but not one who ordinarily lives in your home or who might be a member of your family or of your spouse's family
- prescription drugs and medicines
- diagnostic X-ray examinations
- laboratory examinations
- X-ray, radium, and radioactive isotope therapy

- anesthesia and oxygen
- rental of iron lung or other durable treatment equipment
- artificial limbs and eyes
- professional ambulance service to the initial hospital where treatment is first received
- dental work or cosmetic surgery when necessary to repair accidental injuries occurring while covered by the Plan
- oral examinaton every six months including cleaning and scaling
- dental X-rays, fillings, root canals, extractions
- space maintainers
- partial or full-removable dentures to replace natural teeth extracted while insured for dental benefits under the Plan or replacement if existing dentures were installed five years prior to replacement and no longer are serviceable.

Other dental expenses determined in accordance with policy provisions will be reimbursed at 50 percent once the annual deductible has been satisfied. These include:

- inlays, gold fillings, crowns (including precision attachments for dentures), and

initial installation of fixed bridgework to replace one or more natural teeth extracted while the individual is insured under the Plan for dental benefits

- orthodontic care expense.

Exclusions

Expenses for any of the following listed conditions are not Covered Expenses and, therefore, cannot be considered either toward satisfying a deductible or for reimbursement:

- expenses in connection with an occupational accident or illness
- expenses not authorized by a licensed physician, surgeon, or dentist
- services and supplies to the extent they are not reasonably necessary for treatment of an injury or illness
- expenses in connection with health check-ups, immunizations and/or inoculations
- expenses in connection with eye examinations and the fitting of glasses, or hearing aids
- expenses for travel in conjunction with medical treatment other than necessity of a licensed ambulance.

Certain other exclusions apply to dental treatment charges only, such as the following:

- charges for dentures, bridgework, crowns, and inlays forming abutments, when these are incurred to replace teeth missing and nonreplaced before dental coverage became effective

- charges for services and supplies that are cosmetic in nature, including denture personalization or characterization

- charges for replacement of lost or stolen prosthetic devices.

Pre-Determination Of Benefits (Dental)

The purpose of Pre-Determination of Benefits is to provide useful information to you as well as the dentist in that both may be informed, in advance of treatment, of the estimated benefits payable for the proposed course of treatment whenever this is expected to exceed $100. The designated **Dental Benefits Request Form** is available and will assist in this recommended procedure which works in the following manner:

A dental Form from the dentist of his proposed course of treatment and charges is submitted to the appropriate Personnel office.

The insurance carrier will review the proposed course of treatment in accordance with the policy provisions and will advise the

dentist and insured of the estimated benefit payment.

This procedure is not intended to interfere with the dentist and patient relationship.

If you accept treatment beyond the scope of the approved procedures, the additional expense beyond the approved procedures will become your responsibility.

Should charges for treatment in the amount of $100 or more be submitted for payment without a Pre-Determination of Benefits, the insurance carrier will determine benefits in the same manner as if the claim had been submitted under the normal procedure. The "pre-determination" procedure will not be used as a means to deny benefits otherwise due for dental expense.

About MEDICARE

Eligibility for MEDICARE begins the first day of the month in which you attain age 65; however, you can be eligible for MEDICARE at an earlier age but only after receiving 24 months of Social Security disability benefits.

Part A is one of the two components of MEDICARE and enrollment is automatic with no cost to you once you become eligible. It is intended to assist in those expenses incurred as the result of hospital confinements.

Part B enrollment requires certain actions on the part of the individual, and there is a monthly premium cost which can be deducted from your

monthly Social Security benefit. Expenses applicable to physician charges, ambulance, outpatient hospital, diagnostic and other medical services are included under Part B. After the required deductible (as set out under the provisions of MEDICARE), a reimbursement of 80 percent of the remaining balance can be made.

(These concepts about MEDICARE are general in nature and specific questions should be referred to a Social Security office.)

Any portion of your covered Parts A and B medical expenses which MEDICARE does not recognize may be submitted under the retirement health care Plan.

Since expenses subject to MEDICARE payment considerations must first be recognized before allowances may be made under your retirement health care benefits, expenses should first be filed with MEDICARE.

The "Explanation of Medicare Benefits," which MEDICARE provides, should always be attached when forwarding any claim to the Personnel office for benefits under your retirement health care coverage.

Benefits From Other Plans

Benefits payable under the described coverages are coordinated with benefits payable from any other group insurance program under which an insured member is covered. Benefits otherwise payable under this Plan may be reduced so that the total benefits received from all group plans cannot

exceed 100 percent of covered expenses.

To Claim Your Benefits

In order to receive benefits under the Plan, you must submit a claim. When accumulated covered medical and dental expenses exceed the "deductible" requirement of this Plan (taking into account coordination with other coverage or MEDICARE), a claim should be filed. Forms are available at any Personnel office.

To file your claim, simply:

(1) Complete a **Group Insurance Claim** (Form SS-020) for each hospital confinement. Check (✓) the appropriate block on the Form for those whom you wish paid directly by the insurance carrier. (Payment of the covered expense will automatically be made to the hospital, unless evidence is submitted that charges have been paid by you.) Sign and date the Form, attaching any available billings, but retain a copy for your records.

(2) Attach "Explanation of Medicare Benefits."

(3) Forward to the appropriate Personnel office.

The **Major Medical Expense Log** (Form SS-022) should be used in submitting prescription and/or medical expenses. By the use of this Form, you may record the prescription expenses and keep your receipts. "Explanation of Medicare Benefits" worksheets should be attached in lieu of medical billings when filing a claim.

Reimbursement will be made directly by the insurance carrier.

The **Dental Benefits Request Form** (SS-023) should be completed when submitting actual dental expenses, as well as for "pre-determination" procedures.

Claims Procedure

(See Claims and Review Procedure, page 16 for additional information.)

CHANGES TO REPORT

Certain events could affect a dependent's eligibility or entitlements for benefits. Therefore, the Company should be advised in the event of the following circumstances:

- death of a spouse
- marriage
- divorce
- marriage of any dependent children under age 19, or any change in a dependency status

- MEDICARE entitlement for you or an insured dependent.

TERMINATION OF BENEFITS AND CONVERSION PRIVILEGES

In the event of the retired employee's death, the surviving spouse and eligible dependent children continue to be insured under the retirement health care benefits. However, in the event of remarriage, this coverage terminates. Also, if a surviving spouse, or an insured child, cease to meet the eligibility requirements, coverage also terminates. In such cases (and providing the individual is not then eligible for MEDICARE), an application for an individual policy may be made to the insurance company. This **conversion privilege** must be exercised by making written application and submitting a quarterly premium to the insurance company within 31 days after cessation of coverage. Additional information may be obtained from the appropriate Personnel office.

CLAIMS AND REVIEW PROCEDURE

Pursuant to the Employee Retirement Income Security Act of 1974, an employee benefit plan, as defined in the regulations, shall establish and maintain reasonable procedures to be followed in presenting a claim for benefits under a plan as well as procedures for review if and when a claim is denied. Accordingly, the following procedures shall be applicable with respect to the benefit plan for which the Summary Plan Description is provided in this booklet.

Claims with respect to this Plan subject to these procedures shall be submitted to the Personnel office in the area where you last worked prior to retirement. Such claims shall be deemed to have been filed as of the date received by the respective office.

Following the filing thereof, all claims will be either approved or denied within 90 days of the filing. In some special cases, additional time may be required for a decision. If so, the claimant will be notified in writing and given an explanation of why more time is needed. In which case, the Plan may take up to another 90 days to make a decision. If the claimant does not receive an answer in 90 days (or 180 days if it is a special case), this is the same as a claim denial and the claimant may then use the appeal procedure.

In the event a claim is denied, in whole or in part, the claimant shall be advised of the decision to deny the claim and the notice will set forth:

1. the reason or reasons for the denial including specific reference to pertinent Plan provisions on which the denial is based;

2. a description of additional material or information, if any, which must be submitted in order to perfect the claim and an explanation of why such material or information is necessary; and

3. an explanation of the appeal and review procedures under the Plan.

If a claimant wishes to appeal the decision denying the claim, a written application, requesting review of that decision must be filed by the claimant or his duly authorized representative within 60 days following the claimant's receipt of the claim denial. If desired, written issues and comments may be submitted with the application for review, and the claimant or his representative shall be permitted to review pertinent documents in the preparation of such application. Every application for review shall be submitted to the Personnel Administration Department of the El Paso Natural Gas Company at its home office, El Paso, Texas, and shall be deemed to have been filed as of the date it is received in that office.

When a claim is denied under the Plan described in this booklet to which these procedures are applicable, the insurance carrier shall be responsible for the review and final decision on review. The insurance carrier may require the claimant to submit such additional material or

evidence which it, in its sole discretion, shall deem necessary in conducting its review.

The final decision on review shall be made, except in unusual circumstances, not later than 60 days following the filing of the application for review, and in no event later than 120 days after such filing. The claimant will be notified in writing of the reasons for such extension. The review decision shall be written in a manner calculated to be understood by the claimant and shall contain specific reasons for the decision, as well as references to pertinent Plan provisions on which the decision is based.

All decisions rendered in accordance with the procedures for appeal and review set forth above shall be final and conclusive with respect to all persons.

APPENDIX I

PARTICIPATING EMPLOYER COMPANIES

The El Paso Company

El Paso Natural Gas Company

El Paso Products Company

El Paso Natural Gas Building Company

Desert American Agency, Inc.

Odessa Natural Corporation

El Paso LNG Company

El Paso LNG Service Company

El Paso Energy Resources Company

El Paso Development Company

El Paso Mining & Milling Company

El Paso Marine Company

The list of participating employer companies as shown above is complete as of the date of issuance. When practicable, this list will be updated as changes occur, however, at any time upon written request to the Plan Administrator, you may receive a complete list of participating employer companies.

APPENDIX II

The El Paso Company
2727 Allen Parkway
Houston, Texas

El Paso Natural Gas Company
304 Texas Avenue
El Paso, Texas

El Paso Products Company
620 North Grant
Odessa, Texas

El Paso LNG Company
2919 Allen Parkway
Houston, Texas

Permian Division Office
310 West Texas
Midland, Texas

San Juan Division Office
Reilly Heights
Farmington, New Mexico

Southern Division Office
119 North Stanton
El Paso, Texas

APPENDIX III

The provisions of the Employee Retirement Income Security Act of 1974 (ERISA) entitle all Plan participants to certain rights and protections. Under ERISA, all participants shall be entitled to:

1. Examine, without charge at the locations listed on Appendix II, all Plan documents, including insurance contracts and copies of all documents filed with the U. S. Department of Labor; such as, detailed annual reports and the Plan description.

2. Obtain, upon written request to the Plan Administrator, copies of all Plan documents and other Plan information. There will be no charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

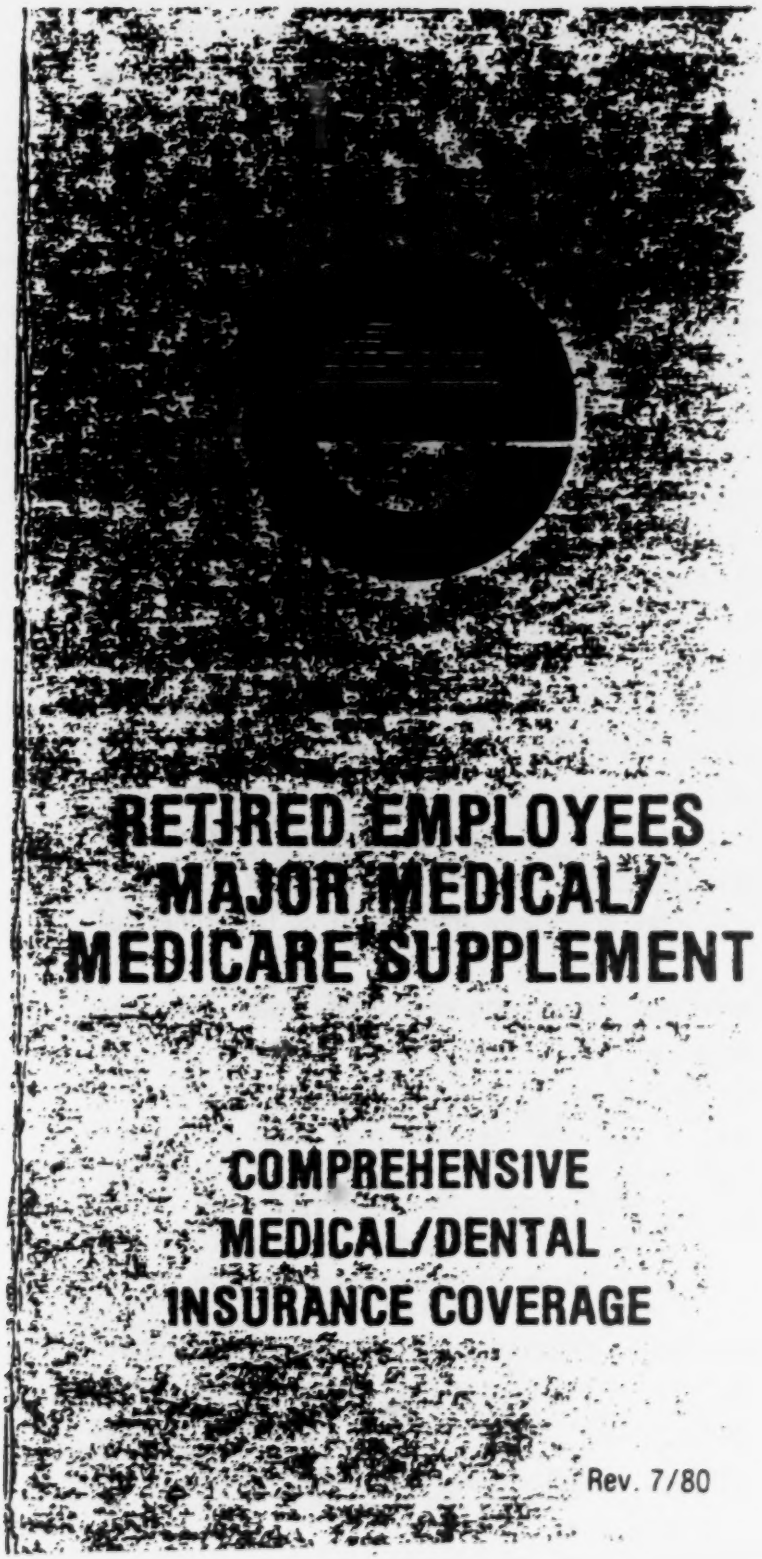
In addition to creating rights for Plan participants, ERISA imposes obligations upon fiduciaries (those persons responsible for the operation of employee benefit plans). Fiduciaries must act solely in the interest of Plan participants and must exercise prudence in the performance of their Plan duties.

No one may discriminate against you in any way to prevent you from exercising your rights under ERISA or from obtaining a benefit. If your

claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered. (See Claims and Review Procedure, page 16.)

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until the materials are received (unless the materials were not sent because of reasons beyond the control of the Administrator). If you have a claim for benefits which you believe has been improperly denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds that your claim is frivolous).

If you have any questions or need additional information about your Plan benefits or rights under the law, contact your Plan Administrator or the nearest Area Office of the U. S. Labor-Management Services Administration, Department of Labor.


RETIRED EMPLOYEES
MAJOR MEDICAL/
MEDICARE SUPPLEMENT
COMPREHENSIVE
MEDICAL/DENTAL
INSURANCE COVERAGE
Rev. 7/80

FOREWORD

Even though health care expenses have dramatically increased during recent years, the Company has continued to maintain a well-rounded health care program which provides the needed protection without any significant increase in cost to the insured. The Company, by paying the total premium, assumes the major impact of spiralling medical costs.

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Rev. 7/80

FACTS ABOUT THE PLAN

NAME OF PLAN

Retired Employees Major Medical/MEDICARE Supplement, Group Policy Numbers GC-40000; GM-40000

TYPE OF PLAN

Insured Welfare Plan providing comprehensive coverage for medical / dental expenses for retired employees and eligible dependents

PLAN NUMBER

501

PARTICIPATING EMPLOYER COMPANIES

The El Paso Company and Affiliated Companies (See Appendix I)

PLAN ADMINISTRATOR

The El Paso Company
2727 Allen Parkway
Post Office Box 2185
Houston, Texas 77001
Area Code 713: 525-9400

TYPE OF ADMINISTRATION

The operation and administration of the Plan is the responsibility of Corporate Employee Relations of The El Paso Company at its corporate headquarters in Houston, Texas 77001.

EMPLOYER IDENTIFICATION NUMBER

74-1782256

DESIGNATED AGENT FOR SERVICE OF LEGAL PROCESS

The El Paso Company
Office of the Secretary
2727 Allen Parkway
Post Office Box 2185
Houston, Texas 77001
Area Code 713: 525-9400

Legal process may also be served upon the Plan Administrator.

SOURCE OF CONTRIBUTIONS TO THE PLAN

The full cost of providing the benefits under this Plan is paid for by the participating employer companies (excluding Special Student Coverage).

INSURER

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06156

PLAN FISCAL YEAR

December 1 - November 30

SEE APPENDIX III FOR A DESCRIPTION OF YOUR RIGHTS AND PROTECTIONS AS PROVIDED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT.

YOUR RETIREMENT HEALTH CARE BENEFITS

Eligibility

Upon retirement, you, your spouse, and eligible dependent children under 19 years of age are automatically insured for retirement health care benefits and the Company pays the entire cost. Eligibility includes:

- regular full-time employees of a participating employer who have been granted a retirement and were covered under the Employees Group Insurance Plan prior to retirement

- a spouse and/or dependent children.

In addition, a surviving spouse continues coverage subject to certain conditions. (See page 15.)

Special Student Coverage is an extension of health care benefits and is available for an unmarried dependent child who is at least age 19, but under age 23, and who is enrolled as a full-time student in an accredited institution of higher learning. Individual applications must be submitted and, although coverage is available at attractive rates, you must pay the monthly premium cost.

Incapacitated or handicapped dependent children may be entitled to an extension of health care benefits if disability commenced prior to the child's 19th birthday and coverage was previously in force under the

group Plan. Subject to application and subsequent approval by the insurance carrier, coverage may be extended beyond the normal age limitations. Applications for this provisional feature of the health care benefits may be obtained from the applicable Personnel office.

Identification cards have been furnished and, hopefully, the card can prove helpful in the event some type of confirmation as to coverage might be needed. If you do not have this card, you should contact the Personnel offices so that a new one can be promptly furnished.

Benefits Of The Plan

Your post-retirement medical and dental coverage includes most of the same definitions and general provisions as did your pre-retirement coverage. These include:

- covered expenses
- exclusions
- deductible carry-over and common accident provisions
- 80 and 50 percent payment after establishing the annual deductible
- $1,000 out-of-pocket provision
- coordination provisions with any other group insurance or MEDICARE coverages.

There are, however, certain variances between the health care benefits for active employees and the retirement health care coverage, in that:

- there is a **deductible** prior to reimbursement for any covered expense, but this annual deductible is only $50 per individual

- $100,000 is the initial lifetime maximum benefit for each insured, but

- at the beginning of each calendar year, there is an automatic restoration up to $1,000 of any used benefits.

The Plan will pay 80 percent of covered medical and certain dental expenses in excess of the deductible in any calendar year (after taking into account any amounts subject to be paid by a primary group carrier or by MEDICARE) until an individual's 20 percent out-of-pocket expenses in one calendar year totals $1,000. After incurring this $1,000 out-of-pocket expense, the Plan will pay 100 percent of all covered expenses for that insured individual for the remainder of that year and, upon satisfying the deductible, for the following year.

Certain specified dental expenses will be reimbursed at 50 percent, once the annual deductible has been satisfied; however, the remaining portion of such expenses does **not** apply to the $1,000 out-of-pocket provision.

The Annual Deductible

Each insured individual has a separate annual

deductible of $50 and only covered expenses may be used to satisfy this deductible.

Last Quarter Carry-Over So that your reimbursable expenses cannot be subject to a deductible late in one calendar year and soon again in the next, any expenses applied against the deductible in the last three months of a calendar year may also be applied against the next year's deductible.

Common Accident If two or more insured members of your family are injured in the same accident, all Major Medical covered expenses which result from that accident during that and the following calendar year will be combined and only one deductible will be charged, regardless of the number of family members involved.

Reimbursement Schedule

After satisfying the "Deductible" (which may be made up from any combination of covered medical or dental expenses), the following will apply:

- 80 percent of covered medical and certain dental expenses until your out-of-pocket expense reaches $1,000; then
- 100 percent of other covered expenses for the remainder of the year and the following year, but after satisfying the deductible
- 50 percent of any other specified dental expense

- an annual maximum payment applicable to basically all dental expenses up to $1,000 per individual which is included in the $100,000 individual entitlement

- the annual automatic restoration provision provides for up to $1,000 of your used benefits at the beginning of each calendar year

- upon payment of an individual's maximum benefits, the respective insured's coverage ceases until eligible for the annual automatic restoration provision.

  (Orthodontic care expenses will be paid at the rate of 50 percent after the deductible is satisfied. There is a maximum lifetime orthodontic benefit of $500 which is separate and apart from the other entitlements.)

Covered Expenses

Covered medical / dental expenses subject to Plan provisions include the reasonable and actual charges which might be incurred for treatment of injury or illness, as well as the reasonable dental expenses generally recognized by professional dental standards. Covered expenses include:

- services of a licensed physician, surgeon, or dentist

- hospital room and board (up to the average semi-private room rate) and other necessary hospital expenses incurred during confinement

- services of a registered graduate nurse or licensed vocational nurse prescribed by your physician — but not one who ordinarily lives in your home or who might be a member of your family or of your spouse's family

- charges made by a home health care agency for services and supplies furnished to an insured individual in the home in accordance with a home health care plan — maximum 120 visits per calendar year. (This provision will not apply to any individual eligible for MEDICARE, inasmuch as MEDICARE provides for this coverage.)

- prescription drugs and medicines

- diagnostic X-ray examinations

- laboratory examinations

- X-ray, radium, and radioactive isotope therapy

- anesthesia and oxygen

- rental of iron lung or other durable treatment equipment

- artificial limbs and eyes

- professional ambulance service to the initial hospital where treatment is first received

- dental work or cosmetic surgery when necessary to repair accidental injuries occurring while covered by the Plan

- oral examination every six months including cleaning and scaling

- dental X-rays, fillings, root canals, extractions

- space maintainers

- partial or full-removable dentures to replace natural teeth extracted while insured for dental benefits under the Plan or replacement if existing dentures were installed five years prior to replacement and no longer are serviceable.

Other dental expenses determined in accordance with policy provisions will be reimbursed at 50 percent once the annual deductible has been satisfied. These include:

- inlays, gold fillings, crowns (including precision attachments for dentures), and initial installation of fixed bridgework to replace one or more natural teeth extracted while the individual is insured under the Plan for dental benefits

- orthodontic care expense.

Exclusions

Expenses for any of the following listed conditions are not Covered Expenses and, therefore, cannot be considered either toward satisfying a deductible or for reimbursement:

- expenses in connection with an occupational accident or illness

- expenses not authorized by a licensed physician, surgeon, or dentist

- services and supplies to the extent they are not reasonably necessary for treatment of an injury or illness

- expenses in connection with health check-ups, immunizations and/or inoculations

- expenses in connection with eye examinations and the fitting of glasses, or hearing aids

- expenses for travel in conjunction with medical treatment other than necessity of a licensed ambulance.

Certain other exclusions apply to dental treatment charges only, such as the following:

- charges for dentures, bridgework, crowns and inlays forming abutments, when these are incurred to replace teeth missing and nonreplaced before dental coverage became effective

- charges for services and supplies that are cosmetic in nature, including denture personalization or characterization

- charges for replacement of lost or stolen prosthetic devices.

Pre-Determination Of Benefits (Dental)

The purpose of Pre-Determination of Benefits is to provide useful information to you as well as the dentist in that both may be informed, in advance of treatment, of the estimated benefits payable for the proposed course of treatment whenever this is expected to exceed $150. The designated **Dental Benefits Request Form** is available and will assist in this recommended procedure which works in the following manner:

A dental Form from the dentist of his proposed course of treatment and charges is submitted to the appropriate Personnel office.

The insurance carrier will review the proposed course of treatment in accordance with the policy provisions and will advise the dentist and insured of the estimated benefit payment.

This procedure is not intended to interfere with the dentist and patient relationship.

If you accept treatment beyond the scope of the approved procedures, the additional expense beyond the approved procedures will become your responsibility.

Should charges for treatment in the amount of $150 or more be submitted for payment without a Pre-Determination of Benefits, the insurance carrier will determine benefits in the same manner as if the claim had been submitted under the normal procedure. The "pre-determination" procedure will not be used as a

means to deny benefits otherwise due for dental expense.

About MEDICARE

Eligibility for MEDICARE begins the first day of the month in which you attain age 65; however, you can be eligible for MEDICARE at an earlier age but only after receiving 24 months of Social Security disability benefits.

Part A is one of the two components of MEDICARE and enrollment is automatic with no cost to you once you become eligible. It is intended to assist in those expenses incurred as the result of hospital confinements.

Part B enrollment requires certain actions on the part of the individual, and there is a monthly premium cost which can be deducted from your monthly Social Security benefit. Expenses applicable to physician charges, ambulance, outpatient hospital, diagnostic and other medical services are included under Part B. After the required deductible (as set out under the provisions of MEDICARE), a reimbursement of 80 percent of the remaining balance can be made.

(These concepts about MEDICARE are general in nature and specific questions should be referred to a Social Security office.)

Any portion of your covered Parts A and B medical expenses which MEDICARE does not recognize may be submitted under the retirement health care Plan.

Since expenses subject to MEDICARE payment considerations must first be recognized before allowances may be made under your retirement health care benefits, expenses should first be filed with MEDICARE.

The "Explanation of Medicare Benefits," which MEDICARE provides, should always be attached when forwarding any claim to the Personnel office for benefits under your retirement health care coverage.

Benefits From Other Plans

Benefits payable under the described coverages are coordinated with benefits payable from any other group insurance program under which an insured member is covered. Benefits otherwise payable under this Plan may be reduced so that the total benefits received from all group plans cannot exceed 100 percent of covered expenses.

To Claim Your Benefits

In order to receive benefits under the Plan, you must submit a claim. When accumulated covered medical and dental expenses exceed the "deductible" requirement of this Plan (taking into account coordination with other coverage or MEDICARE), a claim should be filed. Forms are available at any Personnel office.

To file your claim, simply:

(1) Complete a **Group Insurance Claim** (Form SS-020) for each hospital confinement. Check (✓) the appropriate

block on the Form for those whom you wish paid directly by the insurance carrier. (Payment of the covered expense will automatically be made to the hospital, unless evidence is submitted that charges have been paid by you.) Sign and date the Form, attaching any available billings, but retain a copy for your records.

(2) Attach "Explanation of Medicare Benefits."

(3) Forward to the appropriate Personnel office.

The **Major Medical Expense Log** (Form SS-022) should be used in submitting prescription and/or medical expenses. By the use of this Form, you may record the prescription expenses and keep your receipts. "Explanation of Medicare Benefits" worksheets should be attached in lieu of medical billings when filing a claim.

Reimbursement will be made directly by the insurance carrier.

The **Dental Benefits Request Form** (SS-023) should be completed when submitting actual dental expenses, as well as for "pre-determination" procedures.

Claims Procedure

(See Claims and Review Procedure, page 17 for additional information.)

CHANGES TO REPORT

Certain events could affect a dependent's eligibility or entitlements for benefits. Therefore, the Company should be advised in the event of the following circumstances:

- death of a spouse
- marriage
- divorce
- marriage of any dependent children under age 19, or any change in a dependency status
- MEDICARE entitlement for you or an insured dependent.

TERMINATION OF BENEFITS AND CONVERSION PRIVILEGES

In the event of the retired employee's death, the surviving spouse and eligible dependent children continue to be insured under the retirement health care benefits. However, in the event of remarriage, this coverage terminates. Also, if a surviving spouse, or an insured child, cease to meet the eligibility requirements, coverage also terminates. In such cases (and providing the individual is not then eligible for MEDICARE), an application for an individual policy may be made to the insurance company. This **conversion privilege** must be exercised by making written

application and submitting a quarterly premium to the insurance company within 31 days after cessation of coverage. Additional information may be obtained from the appropriate Personnel office.

CLAIMS AND REVIEW PROCEDURE

Pursuant to the Employee Retirement Income Security Act of 1974, an employee benefit plan, as defined in the regulations, shall establish and maintain reasonable procedures to be followed in presenting a claim for benefits under a plan as well as procedures for review if and when a claim is denied. Accordingly, the following procedures shall be applicable with respect to the benefit plan for which the Summary Plan Description is provided in this booklet

Claims with respect to this Plan subject to these procedures shall be submitted to the Personnel office in the area where you last worked prior to retirement. Such claims shall be deemed to have been filed as of the date received by the respective office.

Following the filing thereof, all claims will be either approved or denied within 90 days of the filing. In some special cases, additional time may be required for a decision. If so, the claimant will be notified in writing and given an explanation of why more time is needed. In which case, the Plan may take up to another 90 days to make a decision. If the claimant does not receive an answer in 90 days (or 180 days if it is a special case), this is the same as a claim denial and the claimant may then use the appeal procedure.

In the event a claim is denied, in whole or in part, the claimant shall be advised of the decision to deny the claim and the notice will set forth:

1. the reason or reasons for the denial including specific reference to pertinent Plan provisions on which the denial is based;

2. a description of additional material or information, if any, which must be submitted in order to perfect the claim and an explanation of why such material or information is necessary; and

3. an explanation of the appeal and review procedures under the Plan.

If a claimant wishes to appeal the decision denying the claim, a written application, requesting review of that decision must be filed by the claimant or his duly authorized representative within 60 days following the claimant's receipt of the claim denial. If desired, written issues and comments may be submitted with the application for review, and the claimant or his representative shall be permitted to review pertinent documents in the preparation of such application. Every application for review shall be submitted to Corporate Employee Relations of The El Paso Company at its corporate headquarters in Houston, Texas and shall be deemed to have been filed as of the date it is received at the corporate headquarters.

When a claim is denied under the Plan described in this booklet to which these procedures are applicable, the insurance carrier shall be responsible for the review and final decision on review. The insurance carrier may require the claimant to submit such additional material or evidence which it, in its sole discretion, shall deem necessary in conducting its review.

The final decision on review shall be made, except in unusual circumstances, not later than 60 days following the filing of the application for review, and in no event later than 120 days after such filing. The claimant will be notified in writing of the reasons for such extension. The review decision shall be written in a manner calculated to be understood by the claimant and shall contain specfic reasons for the decision, as well as references to pertinent Plan provisions on which the decision is based.

All decisions rendered in accordance with the procedures for appeal and review set forth above shall be final and conclusive with respect to all persons.

APPENDIX I

The El Paso Company

El Paso Natural Gas Company

El Paso Products Company

El Paso Natural Gas Building Company

Desert American Agency, Inc.

Odessa Natural Corporation

El Paso LNG Company

El Paso LNG Service Company

El Paso Coal Company

El Paso Development Company

El Paso Mining & Milling Company

El Paso Marine Company

El Paso Algeria Corporation

El Paso Exploration Company

El Paso Polyolefins Company

The list of participating employer companies as shown above is complete as of the date of issurance. When practicable, this list will be updated as changes occur, however, at any time upon written request to the Plan Administrator, you may receive a complete list of participating employer companies.

Finally, if there is any conflict between that which follows in this booklet and the official text of the Plan, the text of the Plan will prevail.

APPENDIX II

The El Paso Company
2727 Allen Parkway
Houston, Texas

El Paso Natural Gas Company
304 Texas Avenue
El Paso, Texas

El Paso Products Company
620 North Grant
Odessa, Texas

El Paso LNG Company
2919 Allen Parkway
Houston, Texas

Permian Division Office
310 West Texas
Midland, Texas

San Juan Division Office
Reilly Heights
Farmington, New Mexico

Southern Division Office
119 North Stanton
El Paso, Texas

APPENDIX III

The provisions of the Employee Retirement Income Security Act of 1974 (ERISA) entitle all Plan participants to certain rights and protections. Under ERISA, all participants shall be entitled to:

1. Examine, without charge at the locations listed on Appendix II, all Plan documents, including insurance contracts and copies of all documents filed with the U. S. Department of Labor; such as, detailed annual reports and the Plan description.

2. Obtain, upon written request to the Plan Administrator, copies of all Plan documents and other Plan information. There will be no charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes obligations upon fiduciaries (those persons responsible for the operation of employee benefit plans). Fiduciaries must act solely in the interest of Plan participants and must exercise prudence in the performance of their Plan duties.

No one may discriminate against you in any way to prevent you from exercising your rights under ERISA or from obtaining a benefit. If your claim for a benefit is denied, in whole or in part, you must receive a written

explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered. (See Claims and Review Procedure, page 17.)

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until the materials are received (unless the materials were not sent because of reasons beyond the control of the Administrator). If you have a claim for benefits which you believe has been improperly denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds that your claim is frivolous).

If you have any questions or need additional information about your Plan benefits or rights under the law, contact your Plan Administrator or the nearest Area Office of the U. S. Labor-Management Services Administration, Department of Labor.